Integration of Behavioral Health and Primary Care, “Best Practices of a FQHC”

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Introduction of Presenters

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Goals

• Build skills to plan, implement and evaluate the integration of behavioral health into primary care
• Build skills to identify the appropriate model that fit each health centers practices
Objectives

• What's the problem with the traditional system
• Define what integrated health care is
• Identify why one should integrate behavioral health and primary care
• Identify integrated models of behavioral health in primary care settings
• Identify the cost benefits for consumers in using integrated care models that includes behavioral health key component
Objectives

- Anticipate ways to apply primary behavioral health model to your practice or clinic
- Recognize strategies to garner staff buy-in to ensure selected integrated model is successful
- Create environment whereby providers and consumers understand their roles in the integrated model
- Develop a work flow that will help to sustain the integrated model within the agency of clinic
Objectives

• Practice forms of communication which will help consumers actively seek primary care that utilizes integrated care models

• Effective develop evaluation tools to evaluate programs on an ongoing bases
What are the Problems with the Traditional System

There are barriers to integrated care on multiple levels including clinical, financial, policy and organizational. These include:

• Fragmentation of care; physical separation of providers
• Separation of medical records; the left hand doesn’t know what the right hand is doing
• Limited communication between medical and mental health providers
• Primary care is often responding to multiple presenting problems creating time management issues
• Primary care providers often have limited training in psychiatric disorders and their treatment; half of those with mental disorders go undiagnosed in primary care
• Primary care patients often have limited access to specialty mental health providers
What is integrated healthcare?

- Integrated health care, often referred to as interprofessional health care, is an approach characterized by a high degree of collaboration and communication among health professionals.

- Barriers to primary care — coupled with challenges in navigating complex healthcare systems — have been a major obstacle to care.

- At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and general health care needs.

- The solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and has been proven to be the most effective approach to caring for people with multiple healthcare needs.

*SAMHSA-HRSA Center for Integrated Health Solutions, accessed 2017*
What is Integrated Health Care (IC)?

- An integrated health care system is one that provides both medical and mental/behavioral health services to address the whole person, not just one aspect of the consumer’s health care needs.
- Medical and behavioral providers collaborate to coordinate the assessment, treatment, and follow-up of both mental and physical health conditions.
- Integrated healthcare reflects a holistic approach to health care that is strengths-based and person-centered. It represents an opportunity to improve care and reduce costs.
Key Elements of Integrated Health Care

• A comprehensive screening and assessment.
• Identification of a patient-centered physical and behavioral health “home” that provides opportunities for collaboration and co-location of services
• The shared development and communication of care plans.
• Care coordination and management to ensure care quality and provide support for consumers and providers.
• Engagement of consumers in self-management and care planning.
Why do consumer access Behavioral Health in Primary Care settings?

- Uninsured or underinsured
- Limited access to public mental health services
- Cultural beliefs and attitudes
- Availability of mental health services, especially in rural areas
Behavioral Health issues seen in Primary Care settings

- Mild to moderate behavioral health issues are common in PC settings
  - Anxiety, depression, substance use in adults
  - Anxiety, ADHD, behavioral problems in children

- People with common medical disorders have high rates of behavioral issues
  - E.g., Diabetes, heart disease, & asthma + depression

- Mental Health problems often go undetected and untreated in primary care
  - When PCPs do detect MH problems, they tend to undertreat them
  - Populations of color, children and adolescents, older adults, uninsured, and low-income patients more often receive inadequate care for MH problems

Mental Illness and Chronic Conditions

Co-occurrence between mental illness and other chronic health conditions:

1. Mental Illness: 21.9% High Blood Pressure
   - No Mental Illness: 18.8%

2. Mental Illness: 36% Smoking
   - No Mental Illness: 21%

3. Mental Illness: 5.9% Heart Disease
   - No Mental Illness: 4.2%

4. Mental Illness: 7.9% Diabetes
   - No Mental Illness: 6.6%

5. Mental Illness: 42% Obesity
   - No Mental Illness: 35%

6. Mental Illness: 15.7% Asthma
   - No Mental Illness: 10.6%

http://www.integration.samhsa.gov/about-us/what-is-integrated-care
Lessons Learned

• Individuals with mental and substance abuse disorders may die 25 years earlier than the general population.

• According to research, behavioral health interventions for patients with serious medical disorders reduces their average length of hospitalization; reduce hospital frequency; decrease the number of prescriptions written; decrease frequency of medical office visits; and decrease the frequency of emergency room visits.

• 70% of all health care visits are generated by psychosocial factors.

Lessons Learned

- 75% of patients with depression present physical complaints as the reason they seek health care.

- According to research, approximately 77% of all antidepressant prescriptions are written by primary care providers.

- 50% of all care for primary care patients with mental disorders is delivered solely by primary medical care practitioners (based on cited epidemiological studies).

- Reveals opportunities to reduce wait time.

Paradigm Shift

PCBH Model

- 30 -35 min visits
- 1-5 visits
- 8-12 patients per day
- Population management
- Open Access
- Any medical issue
- mental health issues
- Goal: enhance overall
- Diagnose and treat health

Traditional Mental Health Model

- 45-60 min visits
- 5 or more visit
- 5-7 patients per day
- Specialty care
- Waiting list
- Mental health issues
- Diagnose and treat DSM disorder
Models of Behavioral Health integration in Primary Care

At the simplest level, integrated mental and physical health care* occurs when mental health specialty and general medical care providers work together to address both the physical and mental health needs of their patients. Integration can work in two directions: either (1) specialty mental health care introduced into primary care settings, or (2) primary health care introduced into specialty mental health settings.

Specialty mental health care introduced into primary care settings

The rationale for the first type of integration is predicated on five main findings from the research literature.

• First, persons with mental health problems often do not receive treatment.
• Second, persons with mental health problems are as likely to be seen in the general medical care sector (23 percent) as in the specialty mental health care sector (22 percent).
• Third, patients are much more likely to see a primary care physician (PCP) each year than a mental health specialist; therefore, PCPs may be in the best position to recognize and improve rates of appropriate treatment.
• Fourth, many people with mental health problems have comorbid physical health problems such as cardiovascular or pulmonary disease, diabetes, or arthritis. Mental health problems exacerbate the disability associated with physical disorders, and patients with such comorbidities consume high levels of medical care services and health care costs. Treating mental health problems among patients with physical health problems, therefore, may potentially reduce overall health care costs.
• Finally, there is a strong body of evidence that effective care for common mental health problems, such as depression and anxiety, can be effectively delivered in the primary care setting, although in usual practice the care often falls below quality standards.

Primary health care introduced into specialty mental health settings

The second broad type of integration refers to integrating primary health care into specialty mental health care settings.

- Such efforts have responded to findings that persons with severe and persistent mental illnesses (SPMI), such as schizophrenia, often do not have their general medical needs adequately addressed.
- Those individuals are at higher risk for medical problems, such as hypertension, coronary heart disease, and diabetes, and have significantly shorter life expectancy than persons without mental illness.
- Moreover, many of the most effective medications for persons with SPMI are associated with physical health problems, especially metabolic syndrome (e.g., obesity, elevated cholesterol, and blood pressure), that further increase the risk for cardiovascular disease and diabetes. These physical illnesses are also often under-treated for the SPMI population.
- Persons with SPMI may also have inadequate access to primary care and preventive services. The drastic difference in morbidity and mortality for persons with SPMI documented in the research—up to 25 years shorter life span compared to the general population—has generated a sense of urgency for governmental bodies and consumer advocacy groups to improve overall care.

Wagner's CCM is widely cited as a way to provide quality care to people with chronic illnesses. This model includes system wide changes in practice organizations such as:

- self-management support,
- delivery system design,
- decision support,
- clinical information systems.

Discrete disease management (DM) programs and support services have proliferated for treatment of specific chronic diseases to improve outcomes and reduce costs. CCM is complementary to the concept of patient-centered care. Both the CCM and DM focus on changing the organization of services from reacting to acute illnesses to proactively coordinating the provision of care. The CCM was conceived to be responsive to needs of patients with multiple comorbidities, and DM has been evolving to acknowledge a “whole person” model as well.

Wagner’s Model continued

Integrated care for mental illnesses uses the same proactive perspective but differs in two important ways.

• One major difference is the concept of collaboration.
  – One use refers to collaboration between patients and health providers in developing care plans to achieve agreed-on treatment goals and ongoing education and support of the patient's self-management of the disease.
  – The second use of “collaboration” refers to collaboration between providers, ensuring that the treatment plan and provision of services is appropriate and coordinated across providers with different expertise and treatment domains.

• The second major difference from the CCM is how this second form of collaboration adds to the complexity of successfully providing sustainable integrated care.
  – Models of collaborative integrated care will not be sufficient without system wide integration.
  – Integration takes place at many levels, including organizational and financial, and is aided or hindered by the cultural integration of mental health, medical health domains, and world views.


Examples of Integrated Services by Discipline

The diagram below provides examples and is not inclusive of all potential integrated services and care.

[Diagram showing integration of services across disciplines: Dental, Medical, Behavioral Health, Pharmacy, and Social Support Services.]

True integration is bi-directional and collaborative

https://youtu.be/S-029Yf7AYM

Cost benefit for consumers

http://www.integration.samhsa.gov/about-us/what-is-integrated-care

INTEGRATION WORKS

Community-based addiction treatment can lead to...

- 35% in inpatient costs
- 39% in ER cost
- 26% in total medical cost

Reduce Risk → Reduce Heart Disease
(for people with mental illnesses)

- Maintenance of ideal body weight (BMI = 18.5 – 25)
  → 35%-55% decrease in risk of cardiovascular disease
- Maintenance of active lifestyle (~30 min walk daily)
  → 35%-55% decrease in risk of cardiovascular disease
- Quit Smoking
  → 50% decrease in risk of cardiovascular disease
Financial Benefits of Behavioral Health Integration

- Use of health care services decreased by 16% for those receiving behavioral health treatment, while it increased by 12% for patients who were not treated for their behavioral health care needs.
- Depression treatment in primary care for those with diabetes had $896 lower total healthcare costs over 24 months.
- Depression treatment in primary care had $3,300 lower total healthcare cost over 48 months.
- Behavioral health disorders account for half of all disability days.
- Annual medical expenses--chronic medical & behavioral health conditions combined -- cost 46% more than those with only a chronic medical condition.
- Of the top five conditions driving overall health care costs (work related productivity + medical + pharmacy cost), depression is ranked number one.


https://www.pcpcc.org/content/benefits-integration-behavioral-health
## Impact of Depression on Medical Cost

<table>
<thead>
<tr>
<th>Condition</th>
<th>Annual Medical Costs per Patient Without Depression ($)</th>
<th>Annual Medical Costs per Patient With Depression ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>2.56</td>
<td>6.74</td>
</tr>
<tr>
<td>Allergic rhinitis</td>
<td>3.27</td>
<td>8.46</td>
</tr>
<tr>
<td>Asthma</td>
<td>3.73</td>
<td>10.56</td>
</tr>
<tr>
<td>Migraine</td>
<td>3.82</td>
<td>15.47</td>
</tr>
<tr>
<td>Back pain</td>
<td>11.61</td>
<td>33.25</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13.06</td>
<td>27.28</td>
</tr>
<tr>
<td>Hypertension</td>
<td>13.38</td>
<td>27.16</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>62.40</td>
<td>110.94</td>
</tr>
</tbody>
</table>

Making integration of behavioral health a success within your agency

- Inspiration
- Challenge
- Clarity
- Task-specific
- Inclusion
Developing your team

• Who should be involved?
  – Your team should consist of everyone who will have to interact with the patient in order to gain full picture of what is needed for the patient.
  – Example: Provider, Nurse, Social Worker, Case Manager, Financial Counselor, Community Health Workers, etc.

• What are their roles?
  – Clearly convey the rational of integrating BH in PC
  – Clearly explain the role of each team member in order to reach optimal health outcomes for consumer
  – All team members to ask questions if they don’t understand their roles and reassign them when necessary

• How often do the team need to meet?
  – Team members should have team huddles daily
  – Team members should meet for the development of the care plan for each patient
  – Team members should meet frequently about evaluation of patients care plans and their connection to the organization’s performance measurements.
Developing a workflow

- Workflow is the sequence of physical and mental tasks performed by various people within and between work environments. It can occur at several levels (one person, between people, across organizations) and can occur sequentially or simultaneously.

- Successful integration of behavioral health and primary care services requires community health provider organizations to analyze workflow for clinical, operational, financial, and quality implications.

- The benefits of addressing workflow issues include increased quality of care, access to services, enrollment, processes, and revenue, as well as reduced wait times, staff time, and documentation.

http://www.integration.samhsa.gov/operations-administration/workflow
Workflow addressed: In this workflow, we are considering the patient who is already receiving behavioral health services at the provider agency and is eligible for the PBHCI program. We are ensuring that the patient sees the primary care provider as soon as possible.

Reason for Workflow: Ensure the appropriate level of engagement of BH professional with the patient’s primary care plan.

Conditions: The behavioral health professional – that is, the individual who has primary responsibility for the patient’s behavioral health care – understands the PBHCI initiative and the requirements for eligibility. They have examined their active caseload and identified patients who are eligible. Since this particular workflow is for an existing patient, an eligibility professional has already determined the patient’s payer source.

Roles: The behavioral health professional takes a leadership role in engaging the patient in the PBHCI initiative. The PBHCI Project Director has already ensured that the BH professional understands the criteria for PBHCI eligibility and how to engage the patient’s interest. The PBHCI Director has the option of enrolling or not enrolling the patient in the project, but referrals of non-eligible patients should not occur. It is counter-therapeutic to refer patients to services for which they are not eligible.
Rational for workflow continues

**Process:** The behavioral health professional is seeing an existing BH patient for a BH appointment. Since they have already determined which of their patients are likely to be eligible (see “Conditions” above), they are prepared to engage this patient in the initiative. In this session they confirm the patient’s status re: whether or not they have a primary care provider; determine their interest in the initiative; confirm that nothing has changed re: the conditions that make them eligible; and ensure that the patient accesses PBHCI primary care as effectively and efficiently as possible.

**Considerations:** The PBHCI project goals and objectives demand the behavioral health professional’s active participation in the patient’s engagement with primary care, and the consideration of treatment for their chronic illness in the behavioral health treatment plan. To meet the project goals and objectives, the “referral loop” between the BH professional and the PC professional must be closed. This means that the BH professional is responsible for making the referral and ensuring the conditions that support the patient’s follow through with the referral are in place (i.e., transportation, support from a peer, etc). The PC provider, who is aware of the referral via the patient’s Continuity of Care Record and a PC appointment, is responsible for reminding the patient of the appointment, ensuring that the supports for attendance are in place and then implementing prompt follow up with the Behavioral Health Professional on the results of the appointment through transmission of the Continuity of Care Record.
Sample Workflow Chart

PBHCI Intake > EXISTING Behavioral Health patients > Getting Patient to Primary Care Exam or Primary Care Appointment

Behavioral Health Professional

- BH patient is eligible.
- Has PC and active patient?
  - No
  - Wants to see PC?
    - No
    - Workflow to monitor patient interest
    - NCM/P available?
      - No
      - Behavioral Health WF for PCP appt.
      - See PBHCI Project PCP follow up WF
    - Yes
      - Workflow for Vital Signs, PC APPS
  - Yes
    - PC available now?
      - Yes
      - Walk patient to PC office to be seen now
      - See PBHCI Project PCP follow up WF
      - No
      - NCM/P available?
        - Yes
        - Walk pt to Nurse Care Manager / Practitioner
        - See PBHCI Project PCP follow up WF
        - No
          - Behavioral Health WF for PCP appt.

Nurse Care Manager/Nurse Practitioner
Evaluating the success of your program

- What distinguishes program evaluation from ongoing informal assessment is that program evaluation is conducted according to a set of guidelines. With that in mind, it defines program evaluation as “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.”

- Program evaluation does not occur in a vacuum; rather, it is influenced by real-world constraints. Evaluation should be practical and feasible and conducted within the confines of resources, time, and political context. Moreover, it should serve a useful purpose, be conducted in an ethical manner, and produce accurate findings. Evaluation findings should be used both to make decisions about program implementation and to improve program effectiveness.

Evaluating the Success of your program

Many different questions can be part of a program evaluation, depending on how long the program has been in existence, who is asking the question, and why the information is needed.

In general, evaluation questions fall into these groups:

- **Implementation**: Were your program’s activities put into place as originally intended?
- **Effectiveness**: Is your program achieving the goals and objectives it was intended to accomplish?
- **Efficiency**: Are your program’s activities being produced with appropriate use of resources such as budget and staff time?
- **Cost-Effectiveness**: Does the value or benefit of achieving your program’s goals and objectives exceed the cost of producing them?
- **Attribution**: Can progress on goals and objectives be shown to be related to your program, as opposed to other things that are going on at the same time?

All of these are appropriate evaluation questions and might be asked with the intention of documenting program progress, demonstrating accountability to funders and policymakers, or identifying ways to make the program better.
Thank You

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